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AN INTERIM SITUATIONAL REPORT ON HIV/AIDS, TUBERCULOSIS, MALARIA, AND POLIO: FRAMEWORK ON ACTION TO ACCELERATE HEALTH IMPROVEMENT IN AFRICA

AN INTERIM SITUATIONAL REPORT ON HIV/AIDS, TUBERCULOSIS, MALARIA, AND POLIO: FRAMEWORK ON ACTION TO ACCELERATE HEALTH IMPROVEMENT IN AFRICA

1. INTRODUCTION

1. The period since the UN Millennium Summit (2000) and Special General Assembly on HIV AIDS (2001) and the Abuja Heads of State Declarations on Malaria (2000) and on HIV/AIDS, Tuberculosis and Other Related Infectious Diseases (2001) has seen greater national, continental and international interest in addressing the health challenges of Africa. However, health status remains poor and is even declining in some instances. Indeed, it is now widely recognised that Africa is not on track to meet the Millennium Development Goals (MDGs), nor indeed many of those set in African and other International forums. Poor health status is ever more acknowledged as not simply a health problem: failure to significantly reduce the burden of disease is prejudicing social and economic development, particularly as investments in health show significant economic returns. Investments in health are productive, not consumptive investments. This was highlighted in the Report of the WHO Commission on Macroeconomics and Health: Investing in Health for Economic Development (2001).

2. In view of the above, this situational report tries to pinpoint key obstacles to progress and identify strategic levers that Heads of State and Government may wish to consider. Anticipating amongst others, the UN and other reviews on progress towards the MDGs, the report of the Commission for Africa and the launch of the World Bank's new health strategy for Africa, 2005 provides a unique opportunity for advocacy and action on removing logjams and accelerating progress in the fight against disease.

3. The report therefore does not aim to provide detailed analyses of the current situation, progress made, constraints faced and action required, as these have already been well enunciated in a number of documents. One such document is "**Scoring African Leadership for Better Health**"[1] which evaluates progress on the Abuja declarations for the period 2000-2003, emphasizes best country practices and highlights the lessons learned. It is a result of the collaborative effort by the African Union Commission (AUC), UN Economic Commission for Africa (UNECA), UNAIDS and WHO. This report is also supported by technical papers prepared by WHO[2,3], UNAIDS[4], UNICEF[5] which have been distributed in the meeting folders.

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[1] This Report will be launched during this Fourth Ordinary Session of the Assembly of Heads of State and Government in Abuja, Nigeria.
[2] Summary Statement on Malaria, HIV/AIDS, Tuberculosis and Polio
[3] Expanding Access to Drugs for HIV/AIDS, Malaria and Tuberculosis
[4] HIV/AIDS Resource Mobilisation, Utilisation and Coordination

4. The Abuja Declarations, reaffirmed by the Maputo Declaration (2003) provide specific direction to the Fight Against AIDS, Tuberculosis and Malaria, while subsequent strategic documents, such as the AU Commission Strategic Plan, AU/NEPAD Health Strategy, and the AU Commission HIV/AIDS Strategic Plan (currently being elaborated) continue to provide an appropriate framework for action.

5. The concern of Heads of State about health has been further reflected in the establishment of the Presidential AIDS Watch Africa (AWA), the support structure of which is now housed in the Social Affairs Department of the AU.

6. Regional Economic Communities are in the process of establishing Health Capacity to fulfil the unique role that they can play. Already Ministers of Health in a number of regions meet annually and will now meet bi-annually at the AU Conference of Health Ministers. However, more effective continental co-ordination of political leadership of health by Ministers, in conjunction with the AU Commission, would be beneficial.

7. Regional and international partners have also been scaling up their efforts to improve the health conditions in Africa.

8. The fight against the burden of disease has been accelerated by a number of actions, including the introduction of anti-retroviral therapy, long-lasting insecticide nets and Artemesinin-based treatments. There is also good evidence of the effectiveness of many interventions, such as immunisation andthe Integrated Management of Childhood Illnesses (IMCI). Measures to eliminate polio reduced paralysis from 75 000 cases in 1996 to 218 in 2002) and river blindness is being obliterated. There is clarity on what needs to be done to reduce the high levels of deaths related to childbirth. What is needed now is to bring the attack on diseases up to the scale required to achieve the desired impact, in conjunction with concerted action to bring about sustainable changes in health systems on the continent. Achieving this will require concerted effort by all stakeholders.

2. HEALTH REALITIES AND CHALLENGES

9. African action is constantly strengthening, with deep commitment to health by many countries. Yet the reality is that Africa is still not on track to meet Millennium Declaration targets for reduction in HIV/AIDS, TB, malaria and infant and maternal mortality, primarily because the scale of the effort is short of what is required. AIDS deaths continue to climb, malaria is resurging widely, maternal mortality is not improving much and mortality rates for under-fives are increasing in places rather than decreasing. The high levels of

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[5] Improving Child Survival in Africa

underlying malnutrition and micronutrient deficiencies are associated with more than half of all childhood deaths. At the same time, other important communicable disease burdens, such as sleeping sickness, continue to devastate communities in parts of the continent and the effect of poorly prevented and treated chronic diseases of lifestyle[6] and road accidents continue to grow. The care situation for those with disabilities and with mental health problems remains inadequate.

10. The box below depicts the stark health reality and the challenges that Africa faces.

Box 1: The Health Reality of Africa

- Each year 2.3 million Africans die of AIDS, and more than a million from both malaria and tuberculosis, while preventable deaths from non-communicable diseases continue to grow.
- More than half the women who die worldwide of conditions related to pregnancy and childbirth are African. Maternal mortality faces 1 in 20 African women compared to 1 in 4 000 in industrialised countries.
- 1 in 6 African children do not reach their fifth birthday, largely from preventable and simple to treat conditions (1 200 000 die annually from pneumonia, 800 000 from diarrhoea, 600 000 from malaria and 500 000 from measles) compared to 1 in 143 in industrialized countries.
- Malnutrition is associated with more than half the under 5 deaths. The problems of underweight children are complicated by micronutrient deficiencies - more than half Africa's children suffer from iron and from Vitamin A deficiencies.
- Less than 1 in 10 of the ~4 million people requiring anti-retrovirals (ARVs) receive them.
- Only 1 in 100 women in Africa who are HIV positive access antiretroviral drugs to prevent the transmission of HIV from mother to child (PMTCT).
- Condom supply is around 3 condoms per year per potential user.
- Less than 10% of children in areas of high malaria prevalence sleep under bed nets and less than half of these are the preferred Long Lasting Insecticide Nets.
- Key immunisations, like Haemophilus Influenza, are essentially not available to African children, only half of whom have received the available immunisations expected by the age of one year.

[6] For example, strokes, heart failure, diabetes

- Africa's share of the $400 billion per annum spent worldwide on medicines is around $5billion.
- Africa has 1 health worker per 1250 people compared to 1 to 97 in Europe,
- Africa has only 1 doctor per 10 000 people.
- Domestic resources for health are around $20 per capita in Africa, compared to around $2000 per capita per annum in high-income countries.
- GDP is estimated to be 2.6% lower than it otherwise would have been in countries with an HIV prevalence of over 20%.
- More than 80% of the continent depends on subsistence agriculture, yet families with a chronically ill head of household plant less than half the average number of crops.

11. The above mini-fact sheet shows that unprecedented action on health is required if we are to get within sight of the Health MDGs and reap the economic and social benefits that this would offer. Heads of State and Government are in a unique position to lead their countries in this effort. Their leadership to set the continent on a path of sustainable growth and development and for peace and stability, good governance and peer review are already making a critical contribution to health and provide a solid platform for future developments. The Abuja Declarations and the reaffirmation of commitments to them in Maputo in 2003 shows the commitment to disease reduction, but Member States are facing many challenges and constraints in their implementation; underlying poverty, malnutrition and limited health systems, including a shortage of human resources and medicines, being prominent amongst these. There is limited access to sustainable and affordable prevention, care and treatment.

12. At the same time, evidence has mounted that investments in health and the fight against disease have yielded significant returns in a number of countries and that the tools and strategies to make an impact are at hand. The main challenge is that programmes against the major burdens of disease are not at the scale required to make the impact desired – to halt and reverse them.

2.1 HIV/AIDS and Tuberculosis

13. The introduction of anti-retroviral therapy with massive training in its use, reductions in the price of medicines, prevention efforts that are beginning to slow rates of new infections and ever stronger leadership by heads of state are amongst crucial advances in many countries.

14. Recognising that the momentum achieved in prevention and treatment must be accelerated further and all partners must support national plans and

co-ordination, WHO and UNAIDS launched the 3x5 programme[7], with a particular emphasis in Africa. There should be a particular emphasis on reaching the poor and most marginalised, on addressing women's vulnerability and on reducing stigma. Supplies of medicines, laboratory tests and condoms need to match service targets. The Fight against AIDS is not just a health problem; all Ministers need to lead their sectors to build a multi-sectoral response.

15. Tuberculosis, a major disease of poverty on its own, is now the main cause of morbidity and mortality among people with HIV/AIDS. More than 90% of countries are now implementing the DOTS[8] strategy and cure rates are increasing. Low human resource capacity is the main constraint to scaling up.

16. Given the extent of HIV / TB co-infection, collaborative programmes, are essential, especially at community and clinic level. Case detection and treatment success rates need to grow and private sector potential needs to be harnessed more effectively.

2.2 Malaria

17. For some time the fight against malaria was struggling and widespread resistance to anti-malarial medicines was growing. Although the search for a vaccine and new drugs remain vital, the advent of long-lasting insecticide treated nets (LLINs) and artemesinin-based medicines and recognition of the value of prudent insecticide spraying, offer the potential to truly roll back malaria. Countries in turn have made significant progress in implementing these interventions, but health system weaknesses prevent rapidly needed treatment and affordability of effective medicines and nets continue to stifle effectiveness of programmes.

18. The right of Africans to receive effective treatment must be given expression through preventive treatment in pregnancy and broad availability of artemisinin-based therapies in all countries. All children in endemic areas should be able to sleep under an insecticide treated net, without cost to the family being a barrier to use. All countries should rationalise taxes and tariffs on nets and insecticides and African capacity to produce LLINs expanded. Development partners need to harmonise their efforts around national plans.

2.3 Polio Eradication

19. Following African leaders commitment in Yaoundé in 1996, Africa achieved faster progress in polio eradication than any other continent. However, a major setback in West and Central Africa since 2003 has seen a re-infection

[7] Launched in December 2003 this programme aims at providing HIV treatment to 3 million people by the end of 2005.
[8] Directly Observed Treatment Support

of 12 previously polio-free countries and a tripling of polio cases. Nonetheless the eradication of the second disease in history remains imminent and polio can still be stopped in 2005.

20. The decisive action by Heads of State and Ministers of Health of affected countries has spearheaded the response to this setback. This led to the largest, synchronised, multi-country mass immunisation campaign in history; launched in Kano State, Nigeria, in October 2004. This high level involvement to ensure quality campaigns and rapid local immunisation in response to cases needs to continue until eradication is achieved. The specific country plans that have been developed to stop polio virus transmission by the end of 2005 must be the focus of all support.

It is recommended that:

- All countries ensure that they have well-developed plans to address each of the major burdens of disease in their country, in a manner that integrates the programmes into the basic health system.

- Public broadcasters are used more widely and creatively in educating communities about action they can take to improve their own health and care.

- Countries commit to mobilizing around and scaling-up prevention, care and treatment in the fight against AIDS, tuberculosis and malaria.

- A commitment is made by polio affected countries that they will ensure that every child is reached during each round of immunization in 2005.

3. KEY ISSUES FOR CONSIDERATION AND REQUIRED ACTIONS

3.1. Integrated and Functional Health Systems

Without an integrated and functional health system little can be achieved: most health systems in Africa are challenged to effectively deliver even basic essential care

21. If programmes against AIDS, tuberculosis, malaria and other major burdens of disease are considered the “packages” that have to be delivered, then the vehicle – the health system, has to be capable of delivering them. Although some countries have made important progress in improving their health systems after the negative impacts of structural adjustment and other factors, many health systems in Africa remain too poorly functional to do their job. Moreover, health strategies have often been fragmented into disease-specific efforts, while HIV/AIDS, tuberculosis, malaria and other diseases may exist in the same person, household, or community. Until citizens have a

functional nearby clinic that offers comprehensive care, including chronic disease and preventive services, and whose treatment they do not have to find money for at the time of acute illnesses, efforts to reduce the burden of disease will not be successful. A functional clinic requires sufficient trained staff, proper equipment, effective medicines and a system for timeously referring complicated cases to an operative district hospital. Progress and evidence show that strengthening health systems must remain at the centre of health efforts. Expert support is effective, but such capacity on the continent is limited.

22. However, as disease has its roots in many sectors – e.g. water, agriculture and transport – health improvement will not be achieved by health sector improvement alone. Every ministry has a role to play in the fight against disease and all ministers need to mobilise action for and ensure that their strategies are pro-health.

It is recommended that countries:

- Establish a team to support rolling out a plan to make one district after another fully functional, decentralising operational management to the district level.

- Move to a single, harmonised planning process for comprehensive health system development that focuses on equity in access to care for all people.

- Support the establishment of African Centres of Excellence and Knowledge Institutions to spur African supported and driven development of health systems.

- Facilitate a process for all Cabinet Ministers to champion a sectoral role in the multi-sectoral fight against disease.

3.2. Human Resources for Health

There is a crisis in human resources for health: there is a shortage of around 1 million health workers

23. Without a driver, the vehicle – the health system – will not deliver. But the reality is that sub-Saharan Africa has only 1.3% of the world's health workforce, although it suffers 25% of the world's disease burden. The workforce density is 0.8 per 1000 population, compared to a world average of 4.2, and then there are severe urban –rural imbalances. Africa's leaders have recognised the critical importance of Human Resources for Health, reflected in a a number of decisions and actions, in particular the Durban Summit (2002)Decision on the Development of Human Resources for Health, coupled with the agreement

to hold an Extra-ordinary Summit on it and the declaration of 2005 as the year for Development of Human Resources.

24. However, their efforts are being hampered by the loss of health professionals to migration. If Africa continues to lose thousands of health professionals annually it cannot achieve an effective health system. Yet, OECD countries seemingly intend to rely on their ability to pull health professionals out of developing countries. In spite of a projected continuing shortfall of tens of thousands of health professionals, they are not stepping up training. Proposed compensation helps financially, but it does not solve the problem of having health professionals in hospitals in Africa.

25. But, the crisis in Africa's health workforce goes much deeper than the shortages and migration of health professionals. The impact on workload of HIV/AIDS, coupled with deaths amongst staff, for example, has a profound impact on already overburdened and overstressed health workers. There are challenges in training, deployment, motivation and retention, severe urban-rural imbalances, poor monetary and non-financial incentives, difficult work conditions and lack of technical competence. A chronic under investment in human resources for health underpins the problem.

26. African Health Ministers have played a key part in taking the Human Resource challenge from a neglected one to the top of the international agenda. An exciting body of evidence is emerging from efforts in a number of African countries of effective interventions that can make a difference. Simple measures, such as personal visits by leaders to health facilities and mechanisms for public appreciation of the good efforts of committed health workers translate into greater dedication to their responsibilities.

It is recommended that countries:

- Determine the categories of professional, auxiliary (mid-level) and community health workers that will provide an appropriate human resource mix for their needs.

- Develop costed national human resources development and deployment plans, including revised packages and incentives, especially for working in disadvantaged areas.

- Forward fund the establishment of the training capacity required to produce the desired number of health workers.

- Build a cadre of multi-purpose trained clinic staff as the nucleus of health care delivery.

3.3. Access to medicines

Medicines remain too expensive: only 3 in 10 Africans have regular access to essential medicines.

27. One of the most intractable problems has been the unavailability of affordable drugs. A number of initiatives, including on trade rules and some drug prices, have resulted in demonstrable progress in the past couple of years. There has also been an increase in efforts to find appropriate new drugs and vaccines with unprecedented new funding and some evaluations of the potential of traditional medicines. But, world capacity is far from being harnessed for identifying urgently needed new formulations. In spite of progress, the reality remains that many Africans do not access even simple basic drugs, products remain too expensive and supply systems are often unreliable.

28. Africa's ability to produce large volumes of quality generic drugs is a critical part of the solution. To achieve this will require African (and international) solidarity to preferentially purchase from African companies so that they can establish themselves in the highly competitive international market. It will also require action to remove poor quality drugs that are flooding the market, further loosening of international trade regulations, efficient registration of new products, industrial development support measures, investment in skills development and removal of trade barriers.

It is recommended that:

- The multi-national pharmaceutical industry is called on to increase their investment in research for drugs and vaccines against the major burdens of disease in Africa and to price more of their products at levels that reflect international solidarity.

- Research into traditional medicines is scaled up and associated intellectual property rights are protected.

- Countries speed up the removal of tariff and non-tariff barriers that are impeding access to pharmaceuticals and other health products in their countries and African products are preferentially purchased.

- Regional Economic Community drug registration systems, accountable to health ministers in the region, are established to facilitate more efficient assessment of medicines, thereby making effective products more rapidly available.

- The AU Commission be requested to, within the framework of NEPAD, lead the development of a Pharmaceutical Manufacturing Plan for Africa.

3.4. Financing Health

Financing remains the major obstacle: investment and innovation is required from countries and development partners to deliver effective health care

29. Current expenditure in most countries is below US$20 per capita per annum, half or less of the US$35-40 minimum required to achieve basic functionality. This amounts to 2.5% of GDP on health against a world average of 5.4%. There is evidence that some countries are indeed increasing their health expenditure, but most remain well short of the 15% of public budget for health committed to in the Abuja Declaration.

30. Similarly, the past few years have seen development aid for health increasing from around US$6 billion towards US$9 billion, but this US$3 billion increase remains well short of the additional US$22 billion required. The first real possibility of significantly bridging this gap comes from the proposed International Financing Facility that would front-load development assistance.

31. However, the financing challenges are deeper than simply the total of funds available – there are questions about the architecture of donor funding and harmonisation, macroeconomic limits and absorption capacity.

32. Historically, much donor funding was channelled to projects separated from the public health system and national plan, sometimes spurred by concerns about the management of public funds. This led to separate vertical programmes that even undermined the core health system and drew out essential staff. There is now a move amongst some donors towards funding core budgets based on national plans, especially where there is good fiscal management and ability to monitor progress to provide evidence of effectiveness. There is also a move for donors to harmonise their funding, so that all parts of the health system are covered.

33. However, positive financing changes and the preparation of Poverty Reduction Strategies (PRS) have come up against a serious obstacle – macroeconomic limits. Treasuries are often committed to or directed towards caps on total public budget growth. Producing a PRS Paper that would truly deliver would exceed these caps and the question has been asked as to where the additional committed funds would be found once the donor cycle is complete. There have been a number of responses to this problem, including donors contemplating longer cycles and some countries producing two PRSPs, one within the fiscal caps (and doomed to fail) and another that required to achieve PRSP targets and the MDGs. In all, there is a need for much greater flexibility, including the introduction of contract posts into the public sector, renewable on the availability of funding.

34. But, increased donor funding of health and budget caps seem to have sparked an unintentional trend. Some Treasuries seem to have reduced their own commitment to health commensurate with increased external funding, resulting in a total health spend that is not much higher than before. The goal of reducing the burden of disease is then sacrificed.

35. Funding is channelled to countries in a number of ways, including through grants and loans, bilateral tied and untied aid and global health partnerships.[9] The latter play an important role in focusing interest on and providing expertise for a particular challenge, but need to ensure that their efforts are integrated effectively into countries systems. Prominent amongst these is the Global Fund to Fight AIDS, TB and Malaria launched by the Secretary General of the United Nations, and endorsed by the Heads of State in Maputo in 2003. When the Secretary General launched the fund he aimed at US$10 billion per annum. Even accounting for forward funding, the first US$10 billion has not been reached.

36. The Global Fund has made an important contribution and is becoming more responsive to criticisms and suggestions. Amongst areas requiring (and receiving) attention is why a number of countries that have put a lot of effort into proposals have still not been funded, why the Expert Technical Review Panel has only 3 Africans amongst its 26 members, why relatively little funding has gone into the area of health systems strengthening and how to speed up the disbursement of grants. (More than US$3 billion has been approved but less than US$1 billion disbursed.) Also, because its grants have been within the envelope of funds available, it has furthered the misconception that Africa cannot absorb more health funds.

It is recommended that:

- Countries track their spending to assess progress against the commitment to reach 15% of public budget for health.

- Treasuries do not to reduce the health spend if donor funding increases and that budget caps that are crippling health system development are reviewed.

- Public/Civil Service Commissions consider creating a mechanism for renewable contract employment of staff so that the concern about future unfunded commitments is obviated.

- Support is given to changes in the architecture of donor funding that could lead to front-loading of aid, core budget support and harmonisation.

[9] For example, Roll Back Malaria, Global Alliance for Vaccines and Immunisation

- A call is made for refinancing of the Global Fund and that the Fund is requested to introduce measures to boost the proportion of fundable proposals, increase African representation on the Technical Review Panel and speed up the disbursement of funds.

- Countries are adamant that global health initiatives and development partners should operate within the framework of country health plans and African determined frameworks.

3.5. Monitoring and Evaluation

Learning from monitoring and evaluation is essential to instil confidence and enhance developments: the multiple mechanisms in place cause duplication and difficulty and need to be harmonised

37. One of the challenges Africa has faced is being able to suitably track progress of its health effort and to rapidly learn from and share its successes. This difficulty has been compounded by the multiple reporting requirements of international agencies and donors, which has led to duplication of effort and ineffective use of scarce resources. The recently established Health Metrics Network aims to harmonise this effort and develop capacity for it, while the proposed African Health Systems Observatory would access relevant data from countries and collate it into easily used continental analyses of health and health system performance. The extent to which Africa can prove its health efforts are working well not only galvanise local communities and health workers, but also spur investment.

38. There have been positive recent developments in health research, but Africa's capacity for research that provides information with which to improve health policy and practice remains very limited. The production and retention of research capacity is a challenge. The 10:90 gap – only 10% of research going into 90% of the world's health problems continues to undermine efforts on the continent to reduce the burden of disease.

It is recommended that:

- Health evaluation in the African Peer Review mechanism is strengthened.

- Countries enhance their data collection systems to more accurately track progress against the Millennium Development Goals.

- Countries support acceleration of the effort to establish an African Health System Observatory.

- Countries support emerging initiatives aimed at growing Africa's health research capacity.

3.6. Up-scaling the Continental Response

Continental and regional institutions have a unique leadership role to play: their added value in co-ordinating efforts and achieving economies of scale must be fully leveraged

39. The African Union Commission has as one of the priority programmes in its strategic plan, the fight against HIV/AIDS, malaria, tuberculosis and other communicable diseases. A strategic plan on HIV/AIDS that will spell out the niche role of the AU Commission itself and provide a roadmap for action being completed. Also, the Presidential AIDS Watch Africa (AWA) is being strengthened to galvanize the continental response to the crisis of HIV/AIDS. A secretariat has been established within the Department of Social Affairs of the AU Commission to provide the necessary support.

40. The AU/NEPAD Health Strategy, adopted in 2002 in Durban, recognised the importance of a comprehensive, integrated approach to addressing the continent's health challenges, overcoming the piecemeal approach that had characterised many previous efforts. The Health Strategy is accompanied by an Initial Programme of Action, which aims to lay a solid foundation for its implementation.

41. Regional Economic Communities have recently strengthened or established Health Desks to enhance regional co-ordination and institutions and a number of regional plans have been developed. The lack of mechanisms for regional funding by donors has inhibited their implementation, but a number have been actioned. More work needs to be done on balancing their role with that of countries and of continental and UN bodies to ensure that duplication is avoided and economies achieved.

It is recommended that:

- Countries support initiatives, both continental and international, that operate within AU and continentally approved strategies to address disease burden.

- Countries ensure that the AU/NEPAD Health Strategy is incorporated into their country's health plan and that the Initial Programme of Action is urgently implemented.

- Regions accelerate the realization of health functionality in Regional Economic Communities.

4. CONCLUSION

42. There are many reasons why 2005 could herald a new phase in the fight against disease on the continent and the misery and suffering it causes. This situational report has outlined the unprecedented focus on health, the nature of the current challenge and the key actions that are required to accelerate health improvement and put Africa back on track to meeting the Health MDGs.

It is recommended that:

- Heads of State endorse the recommendations on reducing disease burden presented to this Summit as the approach towards attaining the health MDGs.

- Heads of State reaffirm their commitment to invest increased resources in health, particularly those mobilised by debt relief, and to address the obstacles impeding such increases.

- Countries prepare inter-ministerial costed development and deployment plans for human resources as the base from which to address the Human Resources for Health crisis.

- Countries commit to taking all the necessary measures to produce quality generic drugs in Africa, supporting industrial development and making full use of the flexibility in international trade law.

- Countries prepare health literacy strategies to achieve an energised continent-wide health promotion endeavour.

TABLE OF CONTENTS

2005

An interim situational report on HIV/AIDS, tuberculosis, malaria, and polio: framework on action to accelerate health improvement in africa

African Union

African Union